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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-815

WHITE PLAINS NURSING HOME, a partnership,
Petitioner,

vs.

COMMISSIONER OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, and ASSISTANT COMMISSIONER OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

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COMMISSIONER OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, and ASSISTANT COMMISSIONER OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

Petitioner White Plains Nursing Home respectfully prays that a writ of certiorari issue to review the judgment of the Court of Appeals of the State of New York entered in this proceeding on June 2, 1977, a timely motion for reargument having been denied on September 9, 1977.

OPINIONS BELOW

The opinion of the Court of Appeals of the State of New York is reported at 42 N.Y. 2d 838, 366 N.E. 2d 79, 397 NYS 2d 378 (1977) and is printed in the appendix to this petition. The Court of Appeals affirmed the opinion of the Supreme Court, State of New York, Appellate Division, Third Department, which is reported at 53 A.D. 2d 926, 385 NYS 2d 392 (1976) and is printed in the Appendix hereto

(A-4). Also printed in the appendix is the Order of Modification of the Appellate Division implementing its opinion (A-7). The Appellate Division, Third Department, modified the Order and Judgment resulting from the opinion of the Supreme Court, State of New York, County of Albany, which is unreported and which is printed in the Appendix to this petition (A-9). The Order and Judgment of the Supreme Court, Albany County, is also printed in the Appendix at (A-16).

JURISDICTION

The judgment of the Court of Appeals of the State of New York was rendered (entered) on June 2, 1977. A timely motion for rehearing by petitioner was denied on September 9, 1977. This petition for certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1257(3).

QUESTION PRESENTED

Do the Due Process Clauses of the Fifth and Fourteenth Amendments require that a Medicaid nursing home Provider receive, pending a hearing, return of Medicaid reimbursement funds cut from the Medicaid reimbursement rate it previously received on the basis of a disputed fact determination by the State made without notice, hearing, or other opportunity for the Provider to review the State's evidence or be heard where:

(1) no statute or regulation requires a prior or post determination hearing with respect to the factual basis of the reimbursement rate cut;

(2) a portion of the reimbursement cut is retroactive to recoup, out of future reimbursement, payments already received by the Provider in prior years;

(3) a portion of the cut is to reduce prospectively the rate of Medicaid realty reimbursement previously established for the Provider and in effect since the opening of its nursing home;

(4) if a subsequent hearing on the fact determination is judicially required, no provision of law requires the hearing to be noticed, concluded or decided within a reasonable or other time period; and

(5) before a hearing will be completed, the Provider will be forced out of business and will incur ruinous financial debt for which its partners are personally liable?

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED

The Fifth Amendment and Fourteenth Amendment. Section 1, to the Constitution of the United States, U. S. Const. amends V and XIV, § 1, N. Y. Public Health Law § 12-a, and 2807, N. Y. Civil Practice Law and Rules § 5519 (a)(1), 42 U.S.C. § 1396a(a)(13)(E), 10 N.Y.C.R.R. § 86.11, 86.14, 86.28, and 86.30 (as in effect on February 1, 1975) and 10 N.Y.C.R.R. § 86-2.7 (as currently in effect) are set forth in the Appendix hereto (A-21 to 42).

STATEMENT OF THE CASE

Petitioner White Plains Nursing Home is a partnership which is licensed by the State of New York to operate a 240-bed nursing home in the Bronx, New York. Petitioner is a Medicaid provider of skilled nursing facility services, for which it is to be reimbursed on a cost-related basis through the Office of the Budget and the Department of Social Services of the State of New York at a rate certified by the Respondent Commissioner of the New York State Department of Health. N. Y. Public Health Law § 2807.

See also 42 U.S.C. § 1396a(a)(13)(E). Petitioner's nursing home is highly rated in quality of patient care and services predominantly Medicaid patients, with approximately one percent Medicare patients and occasional private patients.

In the relevant period here, the Commissioner certified Medicaid realty reimbursement in accordance with regulations, 10 N.Y.C.R.R. Part 86, pursuant to which two realty reimbursement rates were established: (1) an arm's length lease rate ceiling of $1,800 per patient per year for Petitioner's area and (2) a non-arm's length "imputed" rental reimburstment rate of $1,440 per patient per year for Petitioner's area. If a lease was deemed arm's-length, the Medicaid provider was reimbursed as an allowable cost its rental up to the ceiling. If a lease was "non-arm's-length" (i.e. between related organizations, See N.Y.C.R.R. § 86.28 (a)), the provider received Medicaid realty reimbursement at the "imputed" rental rate. The regulation contained no provision for a hearing or other opportunity for the provider to be heard or to submit evidence or to review the Commissioner's evidence with respect to the administrative determination as to the nature of a provider's lease. Usually, the lease was accepted as classified by the provider on reimbursement cost report forms.

The arm's-length standard to be applied by the Commissioner was not officially promulgated as a regulation, nor derived from statute, but was, at the relevant time, as follows:

> "Non-arm's length arrangement:
> An arrangement in which the operator(s) of the facility has an interest of more than 10% in the equity of a company providing real property, goods or services to the facility.
>
> "An 'interest in equity' means an operator(s) has ownership or control, direct or indirect, in such a Company."

> (The standard appeared in a form for reimbursement submissions utilized by the Department of Health.)

Petitioner opened its nursing home in March, 1972. It occupies its premises pursuant to a lease dated December 4, 1971 (R. 38, reference to "R" are to that portion of the record printed for the Court of Appeals below) requiring monthly payment of an annual rental of $432,000 to an unrelated corporation, Cambridge Care Center Corp., its landlord.

From the opening of the home to February 1, 1975, Petitioner received Medicaid realty reimbursement sufficient to cover its lease costs at the arm's-length rate.

In December, 1974, after no notice or warning whatsoever, Petitioner received a letter from Respondent Assistant Commissioner stating:

> "It has been brought to my attention that the lease between you and Cambridge Care Center is not an arm's-length lease. According to our reimbursement rules the rent should be limited to the non-arm's-length rental from the date of opening.
>
> "Effective in the February, 1975 rate an adjustment will be made to recover the overpayment for the period through January, 1975" (R. 26).

In January, 1975, Petitioner received notice that, effective February 1, 1975, its rate was cut in accordance with the December, 1974 letter to the "imputed" Medicaid reimbursement rental rate both prospectively and retroactively for the entire period from the opening of the home (R. 23). Pursuant to the cut, Petitioner fell from $432,000* per year

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* The following figures assume 100% occupancy each day by Medicaid patients. Actually, such occupancy averaged 99%; an error of approximately 1% would be included in each sum, but the ratio of the figures to each other is accurate.

in Medicaid realty reimbursement to $107,280 received thereafter for the entire year 1975. The difference between the arm's-length and non-arm's-length rate for a 240-bed nursing home is $86,400 per year. However, of the $324,720 cut in Petitioner's reimbursement for 1975, $244,520 was retroactive, i.e., to recoup the difference between the arm's-length rate already paid to Petitioner and the "imputed" rental rate for the entire period from the opening of the home in March 1972 to February, 1975.

Petitioner was provided with no advance notice of the determination that its lease was non-arm's-length and had no knowledge or information as to what information, if any, formed the basis for the Commissioner's determination that the lease was non-arm's-length. Petitioner protested the decision and requested an administrative appeal (R. 24), but an administrative appeal was never entertained by the Department (R. 25). Petitioner's administrative remedies were thus exhausted. Petitioner had no opportunity whatsoever to present facts with respect to the nature of its lease to the Department of Health, or to review the Department's evidence. No statute or regulation provided for a prior or post-determination hearing or for any kind of opportunity for Petitioner to be heard or to review the Commissioner's evidence.

Petitioner then brought a special proceeding pursuant to N. Y. Civil Practice Law and Rules, article 78, for review of the determination in Supreme Court, Albany County. The Verified Petition therein alleged that the reimbursement cut resulting from the unilateral determination that the lease was non-arm's-length should be vacated and appropriate relief should be granted because Petitioner was denied its right to a prior hearing to which it was entitled under the Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution, as well as on other grounds (R. 17). A copy of the Verified Petition

is printed in the appendix to establish the timeliness of raising of the Constitutional issues below (A-17). The hearing requested, if required, would be governed by N. Y. Public Health Law § 12-a which established the format for all hearings before the Department of Health. The nature of the hearing requested in this proceeding is not at issue herein.)

During this proceeding, when the Respondents filed their Verified Answer, Petitioner saw for the first time the "evidence" upon which the determination was purportedly based. Petitioner knows its lease to be arm's-length and Petitioner disputed the "evidence" in the article 78 proceeding by its Verified Reply (the Supreme Court did not hold an evidentiary hearing in the article 78 proceeding).

The Supreme Court held that a prior hearing was required and that the Respondents' determination that the lease was non-arm's-length was "without substantial evidence to support it" (R. 14, A. 13).

The Supreme Court entered an Order and Judgment (a) vacating the reimbursement cut, (b) restoring Petitioner to the arm's-length Medicaid realty reimbursement rate, (e) ordering that the accumulated reimbursement already withheld pursuant to the Commissioners' determination be immediately repaid to Petitioner and (d) remanding the matter to the Commissioner for a hearing (R. 5) (A. 15).

The Respondents, however, appealed the decision to the Supreme Court, Appellate Division, Third Department. The relief granted to Petitioner was automatically stayed and no hearing was noticed or held.

On July 1, 1976, the Appellate Division, Third Department, rendered a decision holding that a Due Process hearing was required with respect to the retroactive nature of the rate cut and that a hearing was further required because of the insubstantial evidence upon which the prospective cut was based. However, the Order and Judg-

ment below was modified to deny all other relief to Petitioner. On July 19, 1976, an Order was entered in the Appellate Division, Third Department, modifying the Order and Judgment of the Supreme Court to strike the monetary relief awarded Petitioner to be restored to the arm's-length reimbursement rate.

The Order of the Appellate Division did result in vacature of the reimbursement cut, but this reimbursement rate had already been superseded by a second reimbursement cut made by the Respondents under new regulations, but again on the basis of the assumed non-arm's-length nature of the lease. No date or time for the required hearing was set by the decision or Order of the Appellate Division, or otherwise by statute or regulation. The decision, when read together with the Order of Modification by the Appellate Division, Third Department, reveals that the Appellate Division rejected Petitioner's contention that a prior or immediate hearing, as opposed to a hearing at some future time upon the conclusion of litigation, was required. See also the subsequent similar decision of the Appellate Division, Third Department, in *Park Crescent Nursing Home* v. *Whalen,* 55 A.D. 2d 801, 389 NYS 2d 925 (3rd Dept. 1976).

The Respondents appealed the decision of the Appellate Division, Third Department, to the Court of Appeals. Petitioner cross-appealed, requesting that the relief granted by the Supreme Court, Albany County, reviving the arm's-length rate and returning the funds withheld pending a hearing, be restored. The Order of the Appellate Division, Third Department, requiring a hearing was again stayed pending the appeal to the Court of Appeals pursuant to N.Y. Civil Practice Law and Rules § 5519(a)(1).

The Court of Appeals denied Petitioner's cross-appeal and affirmed the Appellate Division, stating that under the particular facts of this case a hearing was required (A. 2). No mention was made in the decision of Petitioner's

demand by cross-appeal for prompt certification of a rate returning the sums withheld pending a hearing. No mention of Petitioner's due process arguments or due process analysis is contained in the decision.

Petitioner moved timely for reargument of its cross-appeal and its motion for reargument was denied without opinion on September 9, 1977.

Accordingly, the Court of Appeals has held that Petitioner is entitled merely to a future hearing at some unspecified date with respect to the nature of its lease, and has affirmed the vacatur of the already-superseded rate cut. However, the relief granted is meaningless to Petitioner.

The vacatur of the rate cut at issue accomplishes nothing because the rate has already been superseded by a second rate cut, also in litigation. The rate cut contested herein was in effect to January 1, 1976, when incredibly, and in the face of the decision already rendered in this proceeding by the Supreme Court, Albany County, the Respondents again cut Petitioner's Medicaid realty reimbursement under new regulations based on the same determination that its lease was not arm's-length. The second cut of Medicaid realty reimbursement was to zero and continues to date. Petitioner contested this second reimbursement rate cut in Supreme Court, Albany County, and won (A. 43). The Supreme Court, Albany County, again required a hearing and restored Petitioner to the prior rate pending appeal of the instant case. But the relief granted was again stayed pending the Respondents' appeal to the Appellate Division, Third Department, which was argued November 22, 1977.

Moreover, no hearing on the arm's-length or non-arm's length nature of Petitioner's lease has been noticed to date or held, after almost three years from the unjustified reimbursement cut. Respondents have simply failed to notice the hearing, although the decision of the Court of Appeals is now in full force and effect. Even if Respondents had

noticed a hearing, it is uncertain when the hearing would be concluded or when the issue would be administratively decided. *Somers Manor Nursing Home, Inc.* v. *Whalen,* 52 A.D. 2d 998 (3d Dept. 1976). No time schedule for such a hearing is contained in a decision in this case or in any statute or regulation. In Petitioner's experience, other hearings noticed before the Department of Health, pursuant to McKinney's New York Public Health Law § 12-a, have not been decided for a period of over two and one-half years from the date of the notice of hearing, due to scheduling difficulties, adjournments granted by the hearing officer, and delay by the Department of Health in prosecuting the hearing or deciding the issues.

The only relief which would be of practical significance to Petitioner would be that granted by the lowest court, i.e., restoration of the prior arm's-length lease rate and of the money withheld by the Respondents pursuant to the rate cut pending the conclusion of the necessary hearing.

Petitioner has no control over its landlord and is unable to pay the rent. Petitioner has no practical option to expel its Medicaid patients and to admit private "paying" patients. As a result, a foreclosure proceeding affecting the facility is pending by the bank holding the first mortgage on the realty, in which the bank has moved for summary judgment. This proceeding would result in termination of the lease and eviction of Petitioner. An action is also pending by the mortgagee bank against Petitioner for past due rent under the lease to the extent of the mortgage debt. The Court may take judicial notice of these actions which are a matter of public record (A 46, 53).

As a direct result of the refusal of the Court of Appeals to order that the money, withheld in reduced Medicaid reimbursement, be returned to Petitioner prior to a hearing, Petitioner is in jeopardy of losing its business, and has incurred overwhelming financial liabilities because it can-

not satisfy the requirement of its arm's-length lease. In addition, Petitioner's partners are personally liable for debt of the partnership, and do not and did not have the option to operate the nursing home with corporate or other limited liability under the New York Public Health Law. Over $1,000,000 is outstanding under the lease at this date and no relief is in sight under the Court of Appeals decision herein.

REASONS FOR GRANTING THE WRIT

I.

The Decisions of the Court of Appeals is Inconsistent with Decisions of this Court.

Most recently in *Matthews* v. *Eldridge,* 424 U.S. 319 (1976), this Court reiterated that:

> " 'The right to be heard before being condemned to suffer grievous loss of any kind, even though it may not involve the stigma and hardships of criminal conviction, is a principle basic to our society.' *Joint Anti-Fascist Committee* v. *McGrath,* 341 U.S. 123, 168 (1951) (Frankfurter, J. concurring.) The fundamental requirement of due process is the opportunity to be heard 'at a meaningful time and in a meaningful manner.' *Armstrong* v. *Manzo* 380 U.S. 545, 552 (1968)."
>
> *Matthews* v. *Eldridge, supra,* at 333.

In *Matthews* v. *Eldridge, supra* (hereinafter *"Eldridge"*), the court defined the due process test as a flexible one requiring consideration of several distinct factors:

> ". . . first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures

> used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interests including the functions involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."
>
> *Matthews* v. *Eldridge, supra*, at 335.

The Court of Appeals of the State of New York refused to apply this due process test to Petitioner. In fact, no due process analysis whatsoever was contained in its decision. Moreover, when the holding of the Court of Appeals is read together with the facts of this case, in light of the *Eldridge* standard, the Court of Appeals' decision fails to satisfy *Eldridge*.

The fact is that the hearing ordered by the Court of Appeals, in light of its refusal to restore to Petitioner, pending the hearing, the sums unlawfully withheld from its Medicaid reimbursement by Respondents, is the practical equivalent of a denial of Petitioner's right to be heard. By the time a hearing is even scheduled, the nursing home will have been lost, and Petitioner's partners will have become insolvent as a result of personal liabilities to the landlord and mortgagee. Under these circumstances, if the *Eldridge* test is applied to this case, the Court of Appeals decision fails.

Specifically, with respect to the first *Eldridge* consideration (the private interest affected by official action), Petitioner's business and its partners' personal solvency are at stake, as well as, indirectly, the Petitioner's landlord's ownership of the land and building, and the welfare of Petitioner's 240 Medicaid patients. See *Klein* v. *Mathews*, 430 F. Supp. 1005, 1009 (D. N.J. 1977) and cases and authorities cited therein with respect to the phenomena of "transfer trauma" which relates to injuries and deaths of

nursing home patients upon the closing of a nursing home. Moreover, recoupment of money already in Petitioner's hands is at issue, and its interest includes retaining payments already received (and spent), not just its interest in continuing to receive reimbursement at an established rate.

With respect to the second *Eldridge* consideration (the risk of an erroneous deprivation through the procedures used), the risk factor is 100% on the side of error. There is no statutory or regulatory right for Petitioner to be heard, either before or after the final determination resulting in the rate cut. Accordingly, there is no safeguard whatsoever against error. Moreover, procedurally, under the present New York law, two provisions operate to compound the error and the injury to the provider whose rate is unilaterally cut. First, there is N. Y. Civil Practice Law and Rules § 5519 (a)(1), which automatically stays relief granted against the state or state officer until the conclusion of all appeals through the state courts, thus affording no relief from a determination, judicially held to be erroneous, until the appellate process is completed. Secondly, the ongoing nature of the Medicaid reimbursement scheme permits the Commissioner to set a new reimbursement rate at will and at any time, with the provider required to attack each cut independently. Thus, the Commissioner is at liberty to repeat the error in a fashion not subject to the prior litigation; consequently, the process of commencing litigation through final appeal must be repeated before relief can be had.

This combination can, and has in this case, resulted in the repetition of an erroneous administrative determination from which the aggrieved party can obtain no meaningful relief. Only the requirement of a prior hearing, and restoration of the funds cut pending the conclusion of such a hearing, can produce a meaningful result.

Moreover, when a hearing is required, there are no provisions of law regulating the time of its commencement or its conclusion within a reasonable, or any other, time. That the recipient of a reimbursement cut is ultimately entitled to a hearing is little solace from the ravages of delay.

With respect to the third *Eldridge* consideration (the probable value of a prior or immediate hearing), if a hearing is timely granted, Petitioner may issue subpoenas, present evidence, and rebut the Department's evidence. Thus a final record for review in the courts, if necessary, is established. As demonstrated above, under existing procedures, a hearing can only have practical benefit to the claimant if conducted before the reimbursement cut is made, or if reimbursement may not be lowered until a hearing is concluded. If a prior hearing were held, then the recipient of Medicaid reimbursement could ultimately win relief from an erroneous fact determination by judicial review, or as should be the case, the procedure would in most cases result in a proper and informed determination by the Department of Health. Short of forbidding the Commissioner to cut Medicaid rates, a requirement that the cut cannot be effectuated until after a hearing is held is the only fair solution.

As to the final *Eldridge* consideration (the government's interests), the government of the State of New York, and its budget, as well as the federal purse would be only slightly affected by the relief Petitioner requests. The government has absolutely no interest in recapturing sums already paid out over a period of years, to a nursing home, without affording a prior hearing.

With respect to the prospective portion of the reimbursement cut, there have been only three nursing homes in New York State which apparently have been affected by realty reimbursement cuts in any way similar to Petitioner's. Most New York State Medicaid realty reimbursement is based upon leases submitted to, and approved by the Department for reimbursement prior to March, 1975. No other instance of reduction of a realty reimbursement rate to the non-arm's-length or non-lease based reimbursement has occurred, except Petitioner's. Present regulations at 10 N.Y.C.R.R. § 86-2.21 provide for "cost" reimbursement in cases of leases not approved for reimbursement prior to March, 1975 or of leases already approved but also determined not to be "fair and reasonable" or "bona fide" by the Commissioner. No hearing before or after such a determination is required, but the Department of Health has not yet put into effect any reimbursement rate cuts under this provision of the current regulations, and no such determination has been the subject of litigation. All new nursing homes receive realty reimbursement on a building cost basis and the lease rate is no longer a determinative factor for prospective Medicaid realty reimbursement of homes constructed recently.

Moreover, as the Court of Appeals noted in this case, with respect to alteration of Medicaid reimbursement rates other than for realty, a hearing process of sorts is provided for audit adjustments. The Court of Appeals notwithstanding, however, this provision (10 N.Y.C.R.R. § 86-2.7(g)) does not apply to Petitioner's case where the reimbursement cut did not result from an audit of cost submissions by the nursing home but from a reclassification by the Department made outside the audit process.

In addition, it should be noted that hearings are favored by the state statutes and regulations in many other Medicaid provider matters. See section 12a, N. Y. Public Health Law, which sets forth the hearing procedure, and 10 N.Y.C.R.R. § 86-2.7 cited above with respect to hearings on reimbursement audit adjustments, and N.Y. Public Health Law § 2806, 2897(3) and 3391 and 10 N.Y.C.R.R. § 600.6 requiring hearings with respect to revocation, suspension or annulment of hospital operating certificates, nursing home

administrator's licenses, narcotics licenses and approval of hospital or nursing home establishment, respectively.

Petitioner submits that the *Eldridge* test must first of all be applied to this case, as was not done below, and that when *Eldridge* is applied, it requires that Petitioner receive a meaningful right to be heard at a "meaningful time" a standard not met by this Court of Appeal's decision. The *Eldridge* test, when applied to these facts, results in a weighing heavily in favor of Petitioner with virtually no factors weighing in favor of the State against return of Petitioner's money pending the required hearing. Accordingly, the decision of the Court of Appeals, permitting the State to withhold Medicaid reimbursement funds, under an erroneous fact determination, without affording Petitioner the right to be heard until such time as Petitioner faces financial ruination, is in conflict with *Eldridge* and should be reviewed and modified by this Court.

II.

This Case Would Contribute to the Necessary Resolution of Issues Left Open as a Result of the Application of the Flexible Due Process Standard in *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

The flexibility of the standard of due process set down in *Eldridge*, when read together with the prior Supreme Court due process decisions of *Mitchell* v. *W. T. Grant Co.*, 416 U.S. 600 (1974); *Fuentes* v. *Shevin*, 407 U.S. 67 (1972); *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), *Bell* v. *Burson*, 402 U.S. 535 (1971) and has resulted in much litigation over how the standard is to be specifically applied. See *Caswell* v. *Califano*, 46 U.S. L.W. 2046 (D. Me. July 19, 1977); White v. *Mathews*, F2d , 46 U.S. L.W. 2057 (2d Cir. July 18, 1977) (what is the "reasonable time" in which a hearing on termination of Social Security disability bene-

fits must occur) and *Hickey* v. *New Castle Cty.*, 428 F. Supp. 606 (D. Del. 1977), *Mount Sinai Medical Center of Greater Miami, Inc.* v. *Mathews*, 425 F. Supp. 5 (S.D. Fla. 1976); *Mattern* v. *Mathews*, 427 F. Supp. 1318 (E.D. Pa. 1977); *Himmler* v. *Weinberger*, 422 F. Supp. 196 (E.D. Mich. 1976); *Kilfoyle* v. *Heyison*, 417 F. Supp. 239 (W.D. Pa. 1976); *Viverito* v. *Smith*, 421 F. Supp. 1305 (S.D.N.Y. 1976); *Schneider* v. *Whaley*, 417 F. Supp. 750 (S.D.N.Y. 1976); *mod.* 541 F2d 916 (2d Cir. 1976); and *Stolberg* v. *Caldwell*, 423 F. Supp. 1295 (D. Conn. 1976) (the latter cases involve issues of whether a prior hearing is necessary; whether judicial review, if available, satisfies *Eldridge* in the absence of an administrative pre- or post-determination hearing; whether retroactive cuts in government funds require a prior hearing; and whether a prior hearing must occur if no hearing is required by statute or regulation.)

Thus, the question of how long and under what circumstances the government can defer a hearing and still effectuate a cut of government funds must eventually be the subject of further guidance from this Court. In light of this situation, this case presents the opportunity for further clarification after *Eldridge* because (1) it involves clear cut and open due process issues unmuddied by qualifying procedural or factual detours or irrelevancies, and (2) in contrast to *Eldridge*, it involves the outer limits of the due process test (what is the relief if a hearing should be held, but no regulation required a hearing before or after the determination, and the government funds at issue were cut retroactively without a hearing).

Eldridge established only the rule that when an adequate opportunity to be heard existed, a prior hearing will not be required in a case that does not involve the severest hardship. Nevertheless, and perhaps unjustifiably

Eldridge has been read to qualify the earlier hearing cases of *Fuentes* and *Bell* and *Goldberg,* and has been construed, in some cases, by government to hold that a prior hearing is never mandated when a subsequent hearing or litigation after any length of time may occur. The aggrieved recipients of government funds and employment have thus been forced to sue for a clarification of *Eldridge* where, as here, there is no provision for a hearing prior to or shortly after the cut of funds based upon a fact determination or where, as in this case, a post-determination hearing may be judicially ordered, but would then be too long in coming.

In addition, this case involves the issue of what process is due and what relief must be ordered when a retroactive cut in government reimbursement occurs without a prior hearing. No Supreme Court case adjudicates this issue, although under the *Eldridge* test, since the government's interest is virtually nil where it has already paid out the disputed funds to the claimant, it should be, but is apparently not, clear that a prior hearing has been mandated by the Court. Contrast *Mattern* v. *Mathews, supra,* and *Mount Sinai Medical Center of Greater Miami, Inc.* v. *Mattern, supra.*

III.

Petitioner's Hardship and Special Circumstances Warrants Review of the Decision Below.

Although the Medicaid system has produced some widely publicized abuses as revealed by several Congressional and State investigations, the particularly precarious position of a Medicaid nursing home provider in the State of New York should favorably affect the determination of the scope of its due process rights.

The federal and state governments have elected to respond to the public demand for government subsidized

care of the aged and infirm, who cannot afford the great expense of such care, by the Medicaid system whereunder private, non-governmental organizations are to provide the care, own and manage the necessary facilities, and oversee operations. In the nursing home field in the State of New York, this is not a windfall to the proprietary providers involved. First, all government payments for the care provided are at a rate which must be reasonably related to costs incurred by each nursing home (the potential for honest profit thus being limited or non-existent); secondly, government stringently and completely regulates the licensure, operations, equipment and structure of the nursing home; and thirdly, there is not a sufficient market for the services of the nursing home provider, outside of the area which is government funded, because few private citizens can afford such care for any duration.

As a result of these factors, when state government does not properly reimburse the provider, the provider is unable to meet basic costs commitments and has no alternative but to close the nursing home or seek to redress the government determination in the courts. Costs of such litigation against the State are not reimbursed by government, so even if the provider succeeds in court, it will suffer loss to some extent. (Yet there has been need for litigation against the State Department of Health in a multitude of cases. See *Levine* v. *Whalen,* 39 NY 2d 510 (1976); *Severino* v. *Ingraham,* AD 2d, 397 NYS 2d 236 (3d Dept. 1977); *Hurlbut* v. *Whalen,* AD 2d, 396 NYS 2d 518 (4th Dept. 1977); *Bradley* v. *Whalen,* AD 2d, 395 NYS 2d 530 (3d Dept. 1977); *Fahey* v. *Whalen,* 54 AD 2d 1097 (4th Dept. 1976); *Somers Manor Nursing Home Inc.* v. *Whalen,* 52 A.D. 2d 998 (3d Dept. 1976); *Westchester Nursing Home Inc.* v. *Whalen,* 49 A.D. 2d 741 (2d Dept. 1975); *Brandywine Nursing Home, Inc.* v. *Whalen,* 398 N.Y.S. 2d 510 (S. Ct. Alb. Cty. 1977); *Briody* v. *Whalen,* 89 Misc. 2d 296, 390

N.Y.S. 2d 814 (S. Ct. Alb. Cty. 1977); *Birnbaum* v. *Whalen*, 85 Misc. 2d 512, 380 N.Y.S. 2d 590 (S. Ct. Mon. Cty. 1976) (the foregoing include cases deciding the question presented herein in contradictory fashion). Many more cases have been brought at the New York Supreme Court level and are not reported.

Moreover, the provider cannot avoid personal liability in the State of New York in connection with nursing home operation. Thus, although the New York Court of Appeals once held in *Sigety* v. *Ingraham*, 29 N.Y. 2d 110 (1971), that a nursing home had the option to go out of business with respect to a prospective Medicaid reimbursement rate reduction, and so was not entitled to a hearing as no "property interest" was involved, this option could not wholly prevent losses to the provider. The provider is left, even after closing, with liabilities incurred but unreimbursed between the time of the reimbursement cut and the time of the closing of the home, an event which requires notice to, and supervision by, the Department of Health. In addition, the provider would be left with either an extremely expensive and unmarketable building, suitable only for nursing home use, or with an extremely burdensome lease commitment for the physical facility and equipment (unless the closing happened to coincide with the expiration of a lease). Real property or a lease cannot be readily, if ever, transferred to a successor because of the prerequisite of Health Department licensure of the successor and approval of the transfer. Thus, the investment in such property or the lease commitment results in an enormous financial liability and loss to the provider upon premature closing of a home.

Petitioner's case particularly demonstrates this point. Petitioner cannot avoid liability on its realty lease by going out of business. Yet it cannot stay in business because of foreclosure proceedings resulting from its inability to pay

its rent as a result of arbitrary Medicaid realty-reimbursement cuts. In addition, its partners have incurred personal liability of about $1,000,000 on the lease because of the failure of the State to reimburse it. Such onerous and unjustified losses would have been avoided, if either Petitioner had received a prior hearing before the reimbursements cuts were made, or if the Court of Appeals had restored the funds withheld to Petitioner until such time as a hearing was concluded. Such due process protections would seem to be exceptionally fundamental when the results of the failure to provide such protection from arbitrary government action are so severe.

This is not a situation in which a nursing home operator, or Petitioner, if efficient and well-managed, can provide the required services at a cost below its reimbursement income. It is a situation in which denial of cost-related reimbursement, if in a significant amount, results in the inability of the provider to meet its costs. In such circumstances, the provided should have adequate protection against arbitrary and unjustifiable Medicaid reimbursement cuts below an established rate, especially if "retroactive" and in significant amounts.

Petitioner fears that the Medicaid nursing home "scandals" in New York, which have been the subject of much exaggerated press coverage and have been a political issue, have influenced the Respondents in the making of the reimbursement cut at issue here and of the second, similar reimbursement cut now before the Appellate Division, Third Department.* Regardless, however, of these

* One of the Petitioner's partners, as well as, of course, Dr. Bernard Bergman, has been investigated by the State authorities. As appears in the certified record below (see Respondent's Affidavit in Opposition to Petitioner's motion for reargument in the Court of Appeals, and Petitioner's Reply thereto), Petitioner assigned, in June 1977, one-half (½) of its ultimate recovery, upon the conclusion of all litigation and hearings, in this action and in its second proceeding against the State, arising out of the second realty reim-

recent circumstances, Petitioner, who was induced to provide patient care for the people of the State by the actions of federal and state elected officials, deserves meaningful due process protection rather than destruction at the will of the government. Petitioner must look to this Court for protection of its right to be heard before it is driven out of business by unjust means.

CONCLUSION

For the reasons given, Petitioner prays that a writ be granted to review the judgment and opinion below.

Respectfully submitted,

PATRICK W. MCGINLEY,
380 Madison Avenue—Suite 1601,
New York, New York 10017,
Attorney for Petitioner.

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bursement cut resulting from the non-arms-length determination, to the office of the New York State Special Prosecutor in Nursing Home, Health & Social Services. The assignment resulted from the investigation by the State Special Prosecutor of Mark A. Loren, one of Petitioner's partners, in connection with another nursing home. Bernard Izbicki, the remaining partner in Petitioner, has not been and will not be the subject of investigation by the Prosecutor and has no record of criminal charges or conviction. The assignment does not reflect the Prosecutor's evaluation of the merits of Petitioner's cases, and no investigation of the ownership or lease relationship of Petitioner was conducted by the Prosecutor. Neither the rights of Petitioner or Mr. Bernard Izbicki, partner, should be affected by the assignment, and despite the assignment, recovery of one-half of the Medicaid reimbursement funds withheld pursuant to the contested rate cuts would avert the imminent foreclosure and satisfy the mortgagee bank, since the first mortgage payments are substantially lower than the rental payments and were kept current by Petitioner's landlord through December 1976.

As to the remaining rental liability, the ownership of Cambridge Care Center Corp. was assigned by Bernard Bergman pursuant to judicial order to Ramsey Clark, Esq., trustee, as part of a broader assignment of property to be administered in order to satisfy Dr. Bergman's restitution debt to the State of New York. Mr. Clark's chief concern at present is to retain the property in the estate of Dr. Bergman, rather than lose the property through foreclosure.

APPENDIX

STATE OF NEW YORK

COURT OF APPEALS

No. 262

IN THE MATTER OF
WHITE PLAINS NURSING HOME,
Respondent-Appellant,
vs.

ROBERT P. WHALEN, ACTING COMMISSIONER OF THE DEPARTMENT OF HEALTH, &C., &ANO., &C.,
Appellants-Respondents.

LOUIS J. LEFKOWITZ, Attorney-General (CLIFFORD ROWAEL & RUTH KESSLER TOCH of counsel) for appellant-respondent.

PATRICK W. MCGINLEY, SUZANNE ANTIPPAS & JAMES C. SWEENEY, NY City, for petitioner-appellant.

MEMORANDUM:

The order of the Appellate Division should be affirmed.

At this stage the case presents a very narrow issue. We are not concerned with the proper procedure to be followed in future cases in which reimbursement rates are to be fixed as the Commissioner has now adopted a regulation providing for a hearing when a proposed rate revision is disputed (10 NYCRR § 86-2.7, eff. January 25, 1977). The question is simply whether under all the circumstances of this case the courts below erred in directing a hearing in the absence of express statutory or regulatory requirement.

The Commissioner has determined that the lease between the petitioner and its landlord is not an arms length transaction and that, pursuant to regulation, the Medicaid reimbursement rate should be reduced to reflect the true cost

of renting the premises. It is not disputed that the Commissioner has power to adopt a regulation and then to interpret and enforce it. The petitioner's objection is that the ultimate determination in this instance is based on an erroneous, or at least disputed, question of fact regarding the nature of the relationship between the petitioner and its landlord. The determination it should be noted affects the petitioner in two respects. First, it reduces the rate of future reimbursement. Secondly, it provides for further, interim, reduction of the rate to recoup alleged overpayments already authorized and received. This latter consequence in particular regarding recoupment would affect petitioner's substantial interests so that it would be appropriate to provide a hearing to resolve the factual dispute.

• • • • •

Order affirmed, without costs, in a memorandum. All concur.

Decided June 2, 1977.

STATE OF NEW YORK

COURT OF APPEALS

At a session of the Court, held at Court of Appeals Hall in the City of Albany on the ninth day of September A. D. 1977.

Present—HON. CHARLES D. BREITEL, *Chief Judge, presiding.*

Mo. No. 742

IN THE MATTER OF
WHITE PLAINS NURSING HOME,
Respondent-Appellant,

vs.

ROBERT P. WHALEN, ACTING COMMISSIONER OF THE DEPARTMENT OF HEALTH, &C., & ANO., &C.,
Appellants-Respondents.

A motion for reargument in the above cause having been made upon the part of the respondent-appellant and papers having been submitted thereon and due deliberation having been thereupon had, it is

ORDERED, that the said motion be and the same hereby is denied.

JOSEPH W. BELLACOSA
Clerk of the Court

SUPREME COURT

APPELLATE DIVISION—THIRD JUDICIAL DEPARTMENT

July 1, 1976

IN THE MATTER OF WHITE PLAINS NURSING HOME,
Respondent,

vs.

ROBERT P. WHALEN, as Commissioner of Health, *et al.*,
Appellants.

Appeal from a judgment of the Supreme Court at Special Term, entered October 9, 1975 in Albany County, which granted petitioner's application, in a proceeding pursuant to CPLR article 78, to vacate a determination of the Health Department.

The present controversy arises from a determination by the appellants to lower the petitioner's medicaid reimbursement rate. The determination was based upon a finding that a contract between petitioner and Cambridge Care Center to provide nursing care for petitioner not an arm's length transaction. Significantly, included in the lowered 1975 rates was an adjustment to recoup overpayments found for the years 1972 through 1974.

As a preliminary matter, we note that this article 78 proceeding is an improper vehicle to challenge administrative rate making. "An article 78 proceeding, it is settled, may not be utilized to review legislative action (citations omitted), and an order of an administrative agency • • • is deemed a legislative act, at least where no provision has been made for notice and a hearing"(*Matter of Lakeland Water Dist.* v. *Onondaga County Water Auth.*, 24 N Y 2d 400, 407. See, also, *Matter of Kovarsky* v. *Housing &*

Development Admin. of City of N. Y., 31 N Y 2d 184). As administrative rate making is the central issue in this case, we hereby exercise our discretion and convert this proceeding into one for a declaratory judgment (CPLR 103, subd. [c]; *Matter of Broadacres Skilled Nursing Facility* v. *Ingraham*, 51 A D 2d 243).

Special Term concluded that the determination was not supported by substantial evidence and granted judgment vacating the determination and remitting the matter "for proper proceedings and determination", including a hearing. Although there is no provision for notice and a hearing to challenge a medicaid rate determination of the Department of Health (see Public Health Law, art. 28; 10 NYCRR, part 86; *Matter of Broadacres Skilled Nursing Facility* v. *Ingraham, supra*), we are of the view, although not necessarily for reasons the same as those set forth by Special Term, that the unique facts and circumstances of the instant proceeding mandate a hearing.

By letter dated January 27, 1975, petitioner was advised that its medicaid reimbursement rate had been reduced and that "[t]he revised rate is effective for the period February 1, 1975 through December 31, 1975 and *includes an adjustment for the years 1972, 1973, 1974 and for January of 1975*" (emphasis supplied). Although it is clear that a private nursing home has no property right in prospective medicaid rates (*Matter of Sigety* v. *Ingraham*, 29 N.Y. 2d 110), in this case appellant seeks to recoup past overpayments for services performed by petitioner at a rate previously certified by the State. The petitioner undertook to perform its nursing services in reliance upon the said rate and has received the money. Under such circumstances, we must conclude that petitioner has a property right in the alleged overpayments. "Where the exercise of a statutory power adversely affects property rights—as it does in the present case—the courts have *implied* the requirement of

notice and hearing, where the statute was silent" (*Matter of Hecht* v. *Monaghan*, 307 N.Y. 461, 468). The petitioner herein is entitled to a due process hearing on the challenges brought by appellant to its right to keep monies already paid (*Matter of Birnbaum* v. *Whalen*, Misc 2d , 380 N.Y.S. 2d 590; see, also, *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F. Supp. 646).

We also conclude that a hearing, not limited to the question of the recoupment of past payments, is warranted in this case to create an adequate record for review. The primary evidence linking petitioner with Cambridge Care Center is a Dun and Bradstreet report, the accuracy and effect of which is not established sufficiently to allow this court to decide whether appellant's determination that the subject contract was not an arm's length transaction was supported by substantial evidence (see *People* v. *McLaurin*, 38 N.Y. 2d 123).

Judgment modified, on the law, by striking the first, third and fourth paragraphs thereof; matter remitted to the Department of Health for further proceedings not inconsistent herewith, and, as so modified, affirmed, without costs.

GREENBLOTT, J. P., MAHONEY, MAIN, LARKIN and REYNOLDS, JJ., concur.

At a term of the Appellate Division of the Supreme Court of the State of New York, in and for Third Judicial Department, held at the Justice Building in the City of Albany, New York, commencing on the 10th day of May, 1976.

PRESENT—HON. LOUIS M. GREENBLOTT,
Justice Presiding,

HON. A. FRANKLIN MAHONEY
HON. ROBERT G. MAIN
HON. JOHN L. LARKIN
HON. WALTER B. REYNOLDS,
Associate Justices.

Docket No. 28000

In the Matter of WHITE PLAINS NURSING HOME,
Petitioner-Respondent,

against

ROBERT P. WHALEN, Acting Commissioner of the Department of Health of the State of New York, and William F. McCann, Assistant Commissioner Division of Health Economics of the Department of Health of the State of New York,

Appellant.

ORDER OF MODIFICATION

An appeal having been made by appellants from a judgment of the Supreme Court at Special Term, entered on October 9, 1975 in the County of Albany, which granted petitioner's application, in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules, to vacate a determination of the Department of Health of the State of New York, and said appeal having been argued by Clifford A. Royael, Esq., of counsel for appellants, and by Patrick W. McGinley, Esq., of counsel for respondent, and after due deliberation, the Court having rendered a decision on the 1st day of July, 1976, it is hereby

ORDERED that the judgment appealed from be and hereby is modified, on the law, by striking the first, third and fourth paragraphs thereof; matter remitted to the Department of Health for further proceedings not inconsistent herewith, and, as so modified, affirmed, without costs.

ENTER:

JOHN J. O'BRIEN
Clerk

DATED AND ENTERED: July 19, 1976.

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF ALBANY

In the Matter of

WHITE PLAINS NURSING HOME,

Petitioner

against

ROBERT P. WHALEN, Acting Commissioner of the Department of Health of the State of New York, and WILLIAM F. McCANN, Assistant Commissioner, Division of Health Economics of the Department of Health of the State of New York,

Respondents.

SUPREME COURT

Albany County Special Term, July 11, 1975.

Calendar #16

JUSTICE ELLIS J. STALEY, JR., presiding

APPEARANCES:
GASPERINI & SAVAGE, ESQS.
Attorneys for Petitioner
10 East 53rd Street
New York, New York 10022
LOUIS J. LEFKOWITZ
Attorney of the State of New York
State Capitol
Albany, New York

STALEY, JR., J:

This is a proceeding pursuant to CPLR article 78 for a judgment vacating and setting aside the determination of the respondents reducing petitioner's reimbursement rate on the ground that such determination is unsupported and

contrary to the existing facts, arbitrary, capricious and unlawful.

Petitioner is a partnership operating a nursing home at 3845 Carpenter Avenue, Bronx County, City of New York. It was issued a license to operate by the State Board of Social Services on December 18, 1968 at which time the partners were Bernard Izbicki, Mark A. Loren and Anne Weiss Bergman. On January 21, 1969, the Department of Social Services was notified by letter that Anne Weiss Bergman had resigned as licensee and operator of the home effective January 21, 1969. On February 1, 1974, an operating certificate was issued to the partnership by the New York State Department of Health. This certificate stated the operator to be "Partnership (Partners named in Application)". The application for this certificate set forth Mark Loren and Bernard Izbicki as the business owners.

On January 27, 1975, the respondents without a hearing, reduced petitioner's medicaid reimbursement rate from $1,472.00 per patient monthly to $1,349.00 on the ground that the lease between the petitioner and the Cambridge Care Center Corporation, dated December 4, 1973, was not an arm's length arrangement. The letter advising of the adjusted rate, dated January 27, 1975 stated that "The revised rate is effective for the period February 1, 1975 and includes an adjustment for the years 1972, 1973, 1974 and for January of 1975." On February 28, 1975, the petitioner requested a reconsideration and an appeal of the determination. On March 13, 1975, the petitioner was advised "Your appeal will be considered with regard to the 1976 rate provided all deficiencies have been corrected and no new violations exist in 1975."

The petition alleges that the determination reducing the reimbursement rate was made in violation of lawful procedure, and was arbitrary and capricious, all in violation of

the rights of petitioner pursuant to section 12-a of the Public Health Law, the New York Constitution, article 1, section 6 and the Fifth and Fourteenth Amendments of the United States Constitution.

Essentially, petitioner's complaint is that the respondents rendered the determination without affording petitioner an opportunity to present evidence and testimony as to the nature of the lease and the relationship of the parties, and that the determination is contrary to the existing facts and unsupported by substantial evidence.

The answer denies all the allegations of the complaint, except insofar as it is alleged that the respondents are the acting Commissioner of the Department of Health and the Assistant Commissioner Division of Health Economics. It also pleads as a first affirmative defense that the petitioner has not been approved by the Public Health Council to operate the White Plains Nursing Home as required by article 28 of the Public Health Law; that the operating certificate was issued in error because a change of ownership took place and was not approved; and that petitioner, therefore, lacks standing to maintain the proceeding.

A second affirmative defense alleges that an affidavit by the partners dated March 15, 1972 indicates that Anne Weiss Bergman was a partner on that date; that a Dun and Bradstreet report dated June 27, 1974 indicates that Bernard Bergman, the husband of Anne Weiss Bergman, is the owner of the lessor corporation; and that the determination is not, therefore, arbitrary and capricious.

A third affirmative defense alleges that the petition fails to state facts sufficient to entitle the petitioner to relief.

Petitioner's reply to the first affirmative defense denies that approval of the public Health Council was required in that section 2801-a(4) of the Public Health Law did not become effective until June 1, 1970 after the withdrawal of Anne Weiss Bergman as a partner, and alleges that it has

a valid operating certificate in that no hearing to revoke, annul or suspend the certificate has been held as required by section 2806 of the Public Health Law. As to the second affirmative defense, the reply denies that the affidavit of March 5, 1972 indicates that Anne Weiss Bergman was a partner on that date, and asserts that such affidavit merely confirms that she was one of the original licensees. The reply also denies that the Dun and Bradstreet report indicates that the lessor corporation is owned by Bernard Bergman, and asserts upon information and belief that at a time in 1969, unknown to petitioner, Bernard Bergman sold all of his stock in the lessor corporation to Rabbi Bernard Twensky, who owned the corporation at the time of the negotiation and execution of the lease, and who continued to be the owner until the month of June, 1975, when the stock was purchased by Bernard Bergman. It also alleged that the partners, Mark A. Loren and Bernard Izbicki do not have and have never had any relationship, familiar or otherwise with Rabbi Bernard Twensky. The allegation in the third affirmative defense is also denied.

The first affirmative defense by the respondents is insufficient upon its face. Assuming the allegations could be established, the respondents have made no effort to schedule a revocation, suspension or annulment hearing as required by section 2806 of the Public Health Law. It also appears from the documentary evidence that Anne Weiss Bergman withdrew from the partnership on January 21, 1969, and the Department of Social Services was notified of such withdrawal on that date. Section 2801(a) of the Public Health Law which requires approval of a change in a partnership by the Public Health Council did not become effective until June 1, 1970. In addition, section 12 of the Laws of 1970, chapter 617 effective June 1, 1970 also provided: "No existing right or remedy of any character shall be lost, impaired or affected by reason of this act." A

change in the partnership prior to the effective date, June 1, 1970, would not, therefore, require subsequent approval by the Public Health Council.

The evidence relied upon by the respondents as set forth in the second affirmative defense does not fall into the realm of substantial evidence. The affidavit of March 15, 1972 merely states that Anne Weiss Bergman was one of the original licensees of the facility. The purpose for which the affidavit was given would seem most important in view of the notice of withdrawal dated January 21, 1969. In passing, it should be noted that the asserted affidavit of March 15, 1972 is not truly an affidavit, it not being in proper form, although it was probably intended to be such. The Dun and Bradstreet report merely indicates that the lessor corporation was incorporated in New York in May, 1966, and that Bernard Bergman was president. There is no evidence of the accuracy of that report, nor is there any evidence that an investigation had been made as to the accuracy thereof by the respondents.

Section 10(1) of the Public Health Law provides: "The actions, proceedings, authority and orders of the department in enforcing the provisions of the Public Health Law and the sanitary code applying them to specific cases shall at all times be regarded as in their nature judicial, and shall be treated as prima facie just and legal."

"Consequently, the crucial question presented is whether the regulation limiting the reimbursement rates is a reasonable exercise of the Commissioner's authority granted under section 2807 (subd. 3) of the Public Health Law. His determination arrived at by a broad application of specific statutory terms is not to be disturbed if it has a reasonable basis, and is not to be disturbed if it has a reasonable basis and is not arbitrary or capricious." (*Matter of Sigety* v. *Ingraham,* 29 N.Y. 2d 110.)

However, where such determination is challenged as arbitrary and capricious, and factual issues are involved and property rights are affected, the right to a hearing before a final determination must be afforded any persons adversely affected by such determinations in order to determine if the determination "has a reasonable basis".

If a determination of the department is to be regarded as judicial in nature, then the parties affected by that determination must be afforded an opportunity to controvert the allegations and to produce witnesses. In other words, a hearing must be held. By implication, section 10(1) of the Public Health Law requires a hearing. (*Godfrey* v. *Winona Lake Development Co.,* 194 Misc. 905.)

The determination here having been made without a hearing, without apparent substantial evidence to support it and affecting a substantial right of the petitioners, must, therefore, be reversed, and the matter remitted to the Department of Health for proper determination of the issues.

Attorneys for petitioner to submit judgment vacating the determination of the respondents, and remitting the matter to the Department of Health for proper proceedings and determination.

All papers to the Attorneys for petitioner for filing upon entry of the order herein.

Date: September 4, 1975.

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF ALBANY

Index No. 9417-75

In the Matter

of

WHITE PLAINS NURSING HOME

Petitioner,

against

ROBERT P. WHALEN, Acting Commissioner of the Department of Health of the State of New York, and WILLIAM F. MCCANN, Assistant Commissioner Division of Health Economics of the Department of Health of the State of New York,

Respondent.

Petitioner having applied to this court pursuant to Article 78 of the Civil Practice Law and Rules for an order and judgment vacating and annulling respondents' determinations on January 27, 1975 reducing Petitioner's Medicaid reimbursemet rate on the ground that such determination was made without a hearing, without substantial evidence to support it, and in violation of the rights of petitioner pursuant to section 12-a of the Public Health Law, the New York Constitution, Article 1, Section 6, and the Fifth and Fourteenth Amendments of the United States Constitution, and the said application having duly come on to be heard;

And on reading and filing the notice of petition dated May 27, 1975, the petition verified May 26, 1975, the exhibits annexed thereto, all submitted in support of the application; the answer, verified July 3, 1975 and the Affidavit of

Marianne K. Adams sworn to July 2, 1975; the Affidavit of Robert P. Whalen, sworn to July 3, 1975, all submitted in opposition to the application; the Verified Reply dated July 11, 1975; the Attorney General of the State of New York having appeared and submitted a memorandum in support of respondents determination; oral argument and due deliberation having been had and it having appeared that there are no triable issues of fact, the Court thereafter rendered and filed its memorandum opinion in writing on September 4, 1975 granting petitioner's application.

Now, on motion of Gasperini & Savage, attorneys for the petitioner, it is

Ordered and Adjudged that the application of Petitioner be and the same hereby is in all respects granted; and it is further

Ordered and Adjudged that the respondent's determination of January 27, 1975, reducing petitioners Medicaid reimbursement rate from $1,472.00 per patient monthly to $1,349.00 is hereby vacated and the matter is remitted to the Department of Health for proper proceedings and determination; and it is further

Ordered and Adjudged that the petitioner's Medicaid Reimbursement rate is hereby reinstated at the arms length lease rental reimbursement provided to Petitioner prior to the defendant's determination of January 27, 1975; and it is further

Ordered and Adjudged that all reimbursement due petitioner having been withheld pursuant to Respondent's January 27, 1975 determination, is to be tendered to petitioner forthwith.

Enter,

ELLIS J. STALEY
J.S.C.

September 29, 1975

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF ALBANY

Index No.

In the Matter of the Application of
WHITE PLAINS NURSING HOME,
Petitioner,

For a Judgment Pursuant to Article 78 of the Civil Practice Law and Rules,

against

ROBERT P. WHALEN, Acting Commissioner of the Department of Health of the State of New York, and WILLIAM F. MCCANN, Assistant Commissioner Division of Health Economics, Department of Health of the State of New York,
Respondents.

To the Supreme Court of the State of New York, Albany County:

The petition of the White Plains Nursing Home, by its attorneys Gasperini & Savage, respectfully shows:

1. Petitioner is a partnership duly organized pursuant to the laws of the State of New York and licensed by the Department of Health of the State of New York to operate a nursing home at 3845 Carpenter Avenue, County of the Bronx, City of New York, State of New York.

2. On information and belief, Respondents are the Acting Commissioner of the Department of Health of the State of New York and the Assistant Commissioner, Division of Health Economics, the officials charged by law with the

duty of determining and certifying Medicaid provided reimbursement rates for nursing home facilities in the State of New York.

3. Petitioner brings this proceeding to review Respondents' determination, dated January 27, 1975, (attached hereto as Exhibit "A"), which reduced Petitioner's Medicaid reimbursement rate from $1,472.00 to $1,349.00 per patient monthly, on the grounds that said determination was made in violation of lawful procedure, and was arbitrary and capricious, all in violation of the rights of Petitioner pursuant to Section 12-a of the New York Public Health Law, the New York Constitution Article I, Section 6 (1969), and the Fifth and Fourteenth amendments of the United States Constitution.

4. Petitioner's demand, dated February 28, 1975 (attached hereto as Exhibit "B"), for an appeal or a reconsideration of the determination reducing Petitioner's Medicaid reimbursement rate for 1975 has been effectively denied by letter dated March 13, 1975 (attached hereto as Exhibit "C") from Walter Livey, counsel to Respondents, in violation of Petitioner's rights pursuant to the United States Constitution and the Constitution and the Laws of the State of New York, as set forth in paragraph 3, *supra.*

5. Respondent, the Assistant Commissioner, by letter dated December 23, 1974, (attached hereto as Exhibit "D") advised Petitioner that it had been brought to his attention that the lease, dated December 4, 1971, between the Petitioner and the Cambridge Care Center Corporation was not an at arm's length arrangement thereby necessitating a reduction in Petitioner's Medicaid reimbursement rate. Specifically, the Assistant Commissioner stated:

> "It has been brought to my attention that the lease between you and the Cambridge Care Center is not

> an arms-length lease. According to our reimbursement rules the rent should be limited to the non-arms length rental from the date of opening." (Petitioner's Exhibit "D")

Further, Petitioner was not afforded an opportunity or hearing to present evidence and testimony as to the nature of the lease and the relationship between the parties, all in violation of Petitioner's rights pursuant to New York Public Health Law Section 12-a, as well as the aforementioned provisions of the United States and New York State Constitutions.

6. Respondent Assistant Commissioner has failed to apprise Petitioner of the evidence and standards employed in arriving at his determinations regarding the nature of the lease arrangements, in violation of Petitioner's right to due process under the aforementioned provisions of the United States New York State Constitutions.

7. As a result of said arbitrary, capricious and unlawful determination, Petitioner's Medicaid reimbursement funds have been reduced, thereby depriving Petitioner of necessary and essential operating funds. Furthermore, as a result of said unlawful determination by Respondents, Petitioner may be forced to close its nursing home to the detriment of at least 240 persons presently cared for by Petitioner's nursing home.

8. Respondent's determination reducing Petitioner's Medicaid reimbursement rate is unsupported and contrary to the existing facts.

9. Petitioner will suffer irreparable damage as a result of Respondents' illegal, capricious and arbitrary determination, for which it has no adequate remedy at law.

10. Petitioner has exhausted all administrative remedies available to it.

11. No previous application for the relief sought herein has been made by the Petitioner.

WHEREFORE, Petitioner respectfully requests an order vacating and setting aside the Respondents' determination reducing Petitioner's Medicaid reimbursement rate on the ground that such determination is unsupported and contrary to the existing facts, arbitrary, capricious and unlawful, and granting such other and further relief as this court may deem just and proper under the circumstances, together with the costs and disbursements of this proceeding.

GASPERINI & SAVAGE
Attorneys for Petitioner
By (Illegible)
Member of Firm

Dated: New York, New York
May 26, 1975

VERIFICATION

STATE OF NEW YORK }
COUNTY OF NEW YORK } ss.:

MARK A. LOREN being duly sworn, deposes and says:

That he is a partner in the White Plains Nursing Home, the petitioner herein; that deponent has read the foregoing petition and knows its contents; and that the same are true to deponent's own knowledge, except as to matters therein alleged to be upon information and belief, and as to those matters the deponent believes them to be true.

.....
MARK A. LOREN

Sworn to before me this
26th day of May, 1975.

U.S. Const. amend V:

No person shall be held to answer for capital, or otherwise infamous crime, unless on presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use without just compensation.

U.S. Const. amend. XIV, § 1:

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens

of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 U.S.C. § 1396a (a)(13)(E):

(a) A State plan for medical assistance must—

• • • • •

(13) provide—

• • • • •

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; . . .

N.Y. Public Health Law § 12-a:

§ 12-a. Formal hearings; notice and procedure

1. The commissioner, or any person designated by him for this purpose, may issue subpoenas and administer oaths in connection with any hearing or investigation under or pursuant to this chapter, and it shall be the duty of the commissioner and any persons designated by him for such purpose to issue subpoenas at the request of and upon behalf of the respondent.

2. The commissioner and those designated by him shall not be bound by the laws of evidence in the

conduct of hearing proceedings, but the determination shall be founded upon sufficient legal evidence to sustain it.

3. Notice of hearing shall be served at least fifteen days prior to the date of the hearing, provided that, whenever because of danger to the public health it appears prejudicial to the interests of the people of the state to delay action for fifteen days, the commissioner may serve the respondent with an order requiring certain action or the cessation of certain activities immediately or within a specified period of less than fifteen days and the commissioner shall provide an opportunity to be heard within fifteen days after the date the order is served.

4. Service of notice of hearing or order shall be made by personal service or by registered or certified mail. Where service, whether by personal service or by registered or certified mail, is made upon an infant, incompetent, partnership, corporation, governmental subdivision, board or commission, it shall be made upon the person or persons designated to receive personal service by article three of the civil practice law and rules.

5. The attorney-general may prefer charges, attend hearings, present the facts, and take any and all proceedings in connection therewith.

6. At a hearing, the respondent may appear personally, shall have the right of counsel, and may cross-examine witnesses against him and produce evidence and witnesses in his behalf.

7. Following a hearing, the commissioner may make appropriate determinations and issue an order in accordance therewith.

8. The commissioner may adopt, amend and repeal administrative rules and regulations governing the procedures to be followed with respect to hearings, such rules to be consistent with the policy

and purpose of this chapter and the effective and fair enforcement of its provisions.

9. The provisions of this section shall be applicable to all hearings held pursuant to this chapter, except where other provisions of this chapter applicable thereto are inconsistent therewith, in which event such other provisions shall apply.

N. Y. Public Health Law Sec. 2807 (as in effect February 1, 1975):

1. No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law shall purchase, pay for or make reimbursement or grants-in-aid for any hospital, home health service, or health-related service unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service or in the case of a home health agency a valid certificate of approval.

2. Payments for hospital service and health related service, including home health service, made by government agencies or corporations organized and operating in accordance with article nine-c of the insurance law shall be at rates approved by the state director of the budget in the case of government agencies and approved by the superintendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law. Notwithstanding the foregoing, rates of payment for hospital and health-related service made by government agencies, approved by the state director of the budget and in effect March Thirty-first, nineteen hundred sixty-nine, shall continue in effect for the period ending December Thirty-first, nineteen hundred sixty-nine.

3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for pay-

ments for hospital and health-related service, including home health service, are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economics and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified.

4. The commissioner shall notify each hospital and health-related service of its approved rate at least sixty days prior to the fiscal year for which the rate is to become effective.

4. (sic) The commissioner shall not certify to the superintendent of insurance and the state director of the budget that proposed rate schedules for a hospital are reasonably related to the costs of efficient production, as required in subdivision three of this section, unless such hospital is in full compliance with the reporting requirements of this article.

4. (sic) The commissioner of health shall include in costs allocated to in-patient services the net loss

incurred by a voluntary hospital as defined by the commissioner in rendering ambulatory and emergency services, when such net loss is adjusted by any operating surplus attributable to all other hospital services, and payments for in-patient hospital services by governmental agencies, including federal agencies, to the extent authorized by federal law and regulation, and corporations organized and operating in accordance with article IX-C of the insurance law shall include a share of such adjusted net loss which share shall bear the same proportion to the total net loss that the agencies' or corporations' share of in-patient services bears to the total in-patient services. Net loss from the rendering of ambulatory and emergency services shall mean the difference, if any, between the direct and indirect costs which are reasonably related to audited costs of efficient production of preadmission, out-patient, ambulatory, post-discharge and emergency services (exclusive of referred ambulatory, employee or courtesy services), and the audited revenues received for such services. The commissioner shall have the power in determining such loss to audit such revenues with respect to determining whether revenue collection and patient charges are reasonably related to the efficient production of revenues and the minimization of net loss, and to disallow any portion of such loss which such audit determines not to have been reasonably related to the provision of ambulatory and emergency services.

5. Any payments made under the authority of this section shall not preclude payments under any other section of law, notwithstanding any provision of law to the contrary.

Sec. 5519. Stay of enforcement.

(a) Stay without court order. Service upon the adverse party of a notice of appeal or an affidavit of intention to move for permission to appeal stays all proceedings to enforce the judgment or order

appealed from pending the appeal or determination on the motion for permission to appeal where:

1. the appellant or moving party is the state of any political subdivision of the state or any officer or agency of the state or of any political subdivision of the state; or

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Relevant sections and subsections of 10 N.Y.C.R.R. Part 86 (as in effect February 1, 1975):

10 N.Y.C.R.R. Sec. 86.11:

86.11 Computation of basic rate. (a) Basic rates will be computed on the basis of allowable fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates will be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs will be made.

(b) Reimbursement rates for emergency and clinic outpatient services will be computed on the basis of allowable costs for such services and the units of service.

10 N.Y.C.R.R. Sec. 86.14:

86.14 Ceilings on payments. (a) Ceilings as specified below for comparable groups of medical facilities will be established for the computation of reimbursement rates for care provided. The ceilings will be considered prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) In computing the rate for inpatient routine services for hospitals, no amount shall be included that is in excess of 10 percent over the weighted average cost of routine impatient services of all hospitals in the group. For the purpose of this subdivision, routine inpatient services shall not include capital costs, costs of schools of nursing, costs of interns and residents, and costs of ancillary services.

(c) In computing the rate for nursing homes, no amount shall be included that is in excess of 10 percent over the weighted average cost of the administrative, dietary and housekeeping services of all homes in the group as designated in section 86.13, excluding those homes with significant operational deficiencies. In no event shall the total allowable costs, excluding property costs, costs for therapy, costs of prescription drugs, return on net equity capital and incentive allowance, exceed 115 percent of the weighted average cost for all nursing homes in the group, as designated in section 86.13, excluding those homes with significant operational deficiencies. In those nursing homes having significant operational deficiencies, the total allowable costs, excluding property costs, costs for therapy, costs of prescription drugs, and return on net equity capital, shall not exceed the weighted average cost of all nursing homes in the group, as designated in section 86.13, excluding those homes with significant operational deficiencies. Upon correction of the deficiencies, the facility will be returned to its designated group for ceiling purposes.

(d) For nursing homes under the administrative direction of a hospital, and which are located in, adjacent to, or physically connected with the hospital, the maximum allowable costs which will be included in computing the reimbursement rate may be no more than 115 percent of the weighted average cost before ceilings of free standing nursing homes comparable as to size, location and sponsor. For the purposes of this ceiling, property costs, costs for therapy,

diagnostic costs, costs of prescription drugs, return on net equity capital and incentive allowance shall not be included.

(e) For health related facilities, the maximum allowable operational costs may not exceed 60 percent of the comparable ceiling per diem operational costs of nursing homes of comparable size in the same geographic area. For the purpose of computing this ceiling, operational costs are defined as total costs less depreciation on real property, real estate taxes, interest on real property capital indebtedness, insurance on buildings, and real property rental payments.

(f) In computing the rates for care provided by community based home health agencies, no amount may be included in a rate that is in excess of the agency charges or in excess of 110 percent of the weighted average cost of all agencies in their group. For hospital based home health agencies, no amount may be included in a rate that is in excess of 110 percent of the weighted average cost of community based agencies in their area.

(g) For public nursing homes and health related facilities, the maximum allowable operational costs may not exceed the comparable ceiling per diem operational costs of voluntary non-profit facilities of comparable size in the same geographic area. For the purpose of computing this ceiling, operational costs are defined as total costs less depreciation on real property, real estate taxes, interest on real property capital indebtedness, insurance on buildings, and real property rental payments.

(h) (1) In computing the medical facility rates for methadone maintenance treatment programs, no amount shall be included that is in excess of:

(i) For treatment and diagnostic centers, the cost included in the rate for employees' salaries and fringe benefits shall not exceed 115 percent of the customary employee cost, as determined by the

commissioner, by geographic area, required to staff a facility based on care to 300 patients. Such computation shall be based on an allowable staffing consisting of the full time equivalent of one physician, two nurses, six counselors, two vocational specialists, one clinic administrator and six additional non-professional employees.

(ii) For hospital based methadone maintenance treatment programs, the rate shall not exceed 150 percent of the ceiling, by geographic area, as determined in subparagraph (i) of this paragraph.

(2) The State Commissioner of Health may waive the ceiling limitations of this subdivision for those programs which have received the prior budget approval of a State agency and such agency finds and recommends to the State Commissioner of Health that he determines that such costs are reasonably related to the costs of efficient production of such services.

10 N.Y.C.R.R. Sec. 86.21:

86.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs will be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (medicare) program.

(b) Allowable costs may not include costs for open heart surgery or renal dialysis, except for emergencies, in facilities not approved by the State Commissioner of Health for this service.

(c) Allowable cost will include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs in computing outpatient rates for payments by government agencies may include a loss incurred by a medical facility as a result of the failure of a person eligible for State medical assistance to pay the copayment related to outpatient services.

(e) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (medicare) costs or in excess of customary charges to the general public. This provision will not apply to services furnished by public providers free of charge or at a nominal fee.

(f) Salaries paid to physicians employed by nursing homes may be considered as allowable costs to the extent that such costs are reasonably related to the services provided, and are not in excess of an amount that would be paid on a fee for service basis.

(g) Reserved.

(h) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(i) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(j) Allowable costs shall include the net loss incurred by a voluntary hospital in rendering ambulatory and emergency services when admission to these services is not restricted by race, creed, color, sex, national origin or sponsor considerations. Such net loss shall be determined as follows:

(1) Inpatient hospital rates for voluntary hospitals certified by the Commissioner of Health for

payment by article I-XC corporations, effective January 1, 1975, shall include that portion of the hospital's net loss from providing ambulatory and emergency services, adjusted and computed as per paragraphs (2), (3), (4), (5) and limited as per paragraphs (6) and (7) of this subdivision, that reflects the ratio of patient days of inpatient care furnished to article IX-C subscribers to the total inpatient days of the voluntary hospital.

(2) The ambulatory and emergency services loss shall be determined by comparing the New York State stepdown cost derived from the uniform financial reports filed for the base year used for reimbursement rate purposes to the net revenue reported on the uniform financial report for outpatient services with the following adjustments:

(i) Referred ambulatory care costs and revenues are to be excluded;

(ii) Ambulatory and emergency costs and revenues of employee or courtesy services are to be excluded;

(iii) Governmental subsidies shall be excluded;

(iv) Revenues which are treated as recoveries of expense and which reduce stepdown cost computed in accordance with this paragraph shall be excluded from revenue.

(3) Any loss computed in accordance with paragraph (2) of this subdivision shall be adjusted by any excess revenues over expenses resulting from all other hospital services with revenues and expenses considered as defined below for purposes of this section:

(i) The revenue to be considered will be the total revenue of the hospital from services directly related to hospital patient care, exclusive of the following:

(a) gifts, grants, bequests and devises, and the income therefrom;

(b) gains or losses resulting from investment transactions or sale of hospital properties and income from restricted funds;

(c) revenue from ambulatory and emergency services (already considered in computing a deficit in paragraph [2] of this subdivision), but not including referred ambulatory services;

(d) governmental deficit financing grants which have not been excluded under subparagraph (iii) of paragraph (2) of this subdivision;

(e) payments made by article IX-C corporations under this section;

(f) revenues attributable to expenses specified in article 28 of the Public Health Law as non-reimbursable.

(ii) Expenses to be considered will be the total expenses of the hospital for services directly related to hospital patient care, exclusive of the following:

(a) ambulatory and emergency service expenses but not including referred ambulatory expenses;

(b) expenses incurred in soliciting gifts, grants, bequests and devises;

(c) expenses specified in article 28 of the Public Health Law as non-reimbursable;

(d) expenses which are not reasonably related to the efficient production of service in accordance with the reimbursement formula approved by the Commissioner of Health and as computed by the article IX-C corporation.

(4) The net loss computed in accordance with paragraph (2) of this subdivision when adjusted by any surplus by the excess of subparagraph (i) of paragraph (3) over subparagraph (ii) of paragraph (3) of this subdivision will be the amount available for article IX-C corporation participation.

(5) The article IX-C corporation share of such identified adjusted net loss will be computed by dividing such loss by the total inpatient service days of the facility. The resulting amount will be an identified addition to the computed article IX-C corporation reimbursement rate to be submitted for certification by the Commissioner of Health.

(6) The commissioner shall have the right in determining losses from ambulatory services to audit ambulatory revenue with respect to determining whether revenue collection and patient charges are reasonably related to the efficient production of revenue and the minimization of net loss, and to disallow any portion of such loss, which such audit determined not to have been.

(7) In the event that the recording of ambulatory revenue in an individual hospital does not conform to generally accepted accounting principles, the commissioner will not calculate the net loss incurred by a voluntary hospital in rendering ambulatory and emergency losses nor will prospective payment rates in such event include the net loss incurred in rendering ambulatory and emergency services.

10 N.Y.C.R.R. Sec. 86.28:

86.28 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to the medical facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate will include both the costs of the related organization in providing the services, facilities and supplies and a return on the equity capital of the related organization.

10 N.Y.C.R.R. Sec. 86.30:

86.30 Temporary rental allowance; proprietary nursing homes. Within the rate of payment for proprietary nursing homes an amount may be included as an allowable cost as "imputed rental" in the computation of the rate of payment. This amount, if included, is in lieu of depreciation, interest on capital indebtedness, insurance on property and return on investment in real estate and nonmovable equipment.

Rental Reimbursement Schedule Adopted By The Department of Health During The Relevant Period (Not Officially Filed With The Secretary of State of New York)

Imputed Rental Allowance Schedule

(New York City, Nassau, Suffolk, Rockland and Westchester Counties)

Year	I Arms Length Rental Maximum	II Non-Arms Length Imputed Rental	III Imputed Rent for Homes Not in Compliance with Structuarl Code Non-fire Resistive—Sprinklered (90% of Col. I or II)	IV Imputed Rent for Home Not in Compliance with Structural Code Non-fire Resistive—Not Sprinklered (80% of Col. I or II)
1975				
1974				
1973				
1972				
1971	1800	1440		
1970	1600	1280		
1969	1400	1120		
1968	1300	1040		
1967	1200	960	864	768
1966	1150	920	828	736
1965	1100	880	792	704
1964	1050	840	756	672
1963	1000	800	720	640
1962	960	768	691	614
1961	920	736	662	589
1960	880	704	634	563
1959	840	672	605	538
1958	800	640	576	512
1957	780	624	562	499
1956	760	608	547	486
1955	740	592	533	474
1954	720	576	518	461
1953	700	560	504	448
1952	680	544	490	435
1951	660	528	475	422

Year	I Arms Length Rental Maximum	II Non-Arms Length Imputed Rental	III Imputed Rent for Homes Not in Compliance with Structural Code Non-fire Resistive—Sprinklered (90% of Col. I or II)	IV Imputed Rent for Home Not in Compliance with Structural Code Non-fire Resistive—Not Sprinklered (80% of Col. I or II)
1950	640	512	461	410
1949	620	496	446	397
1948	600	480	432	384
1947	580	464	418	371
1946	560	448	403	358
1945	540	432	389	346
1944	520	416	374	333
1943	500	400	360	320
1942	480	384	346	307
1941	460	368	331	294
1940	440	352	317	282
1939	420	336	302	269
1938	400	320	288	256
1937	380	304	274	243
1936	360	288	259	230
1935	340	272	245	218
1934	320	256	230	205

10 N.Y.C.R.R. Sec. 86-2.7 (as currently in effect):

86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. In this respect, any rate of payment certified by the State Commissioner of Health based on the initial submission of base year data and reports will be construed to represent a provisional rate until such audit is performed and completed at which time such rate or adjusted rate will be construed to represent the final rate.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the rec-

ords of residential health care facilities, in a manner to be determined by the State Department of Health.

(c) Audits must be completed within six years from the due date of the report or the date of their filing with the department, whichever is later. This limitation shall not apply to situations in which fraud may be involved.

(d) Upon completion of the audit the residential health care facility shall be notified of the time and place of a closing conference. The residential health care facility may appear in person or by any one authorized in writing to act on behalf of the residential health care facility. The residential health care facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The residential health care facility shall thereafter be provided with the final audit report, the rate computation sheet and the rate, which shall be final unless within 30 days of receipt of the final audit report, the residential health care facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and forwarding all material documentation in support of the residential health care facility's position.

(1) The division upon receipt of such request, shall assign such report to a staff person who shall review the audit report with the residential health care facility and shall reduce to writing the substance of any agreement reached and any unresolved items, setting forth the position of the residential health care facility and the Department on such unresolved issues.

(2) Every effort shall be made to resolve any disagreement at the bureau review and if resolution is

not reached to reduce to writing a statement of the facts and issues.

(3) Any adjustments to the audit report, statement of agreement or statement of position as the result of the bureau review shall be final unless, within 30 days of the receipt thereto, the residential health care facility initiates a review by the rate review panel by notifying the Division of Health Care Financing by registered or certified mail that such review is requested. The residential health care facility shall submit with such notification all documentation deemed by residential health care facility to be relevant to such review and in the absence of agreement as to facts shall set forth in clear and concise terms each and every error which the residential health care facility alleges has been made together with a statement of the fact or law upon which the residential health care facility relies.

(f) The rate review panel shall consist of a deputy commissioner and two independent consultants. It shall review all material presented to it with the assistance of department staff and shall make its recommendations to the commissioner. The panel shall meet at such time and place as designated by the first deputy commissioner.

(g) The commissioner shall, upon receipt of the recommendation of the rate review panel, make a determination of the controverted items of the final audit report and the rate as adjusted in accordance with such determination, which rate shall be final except that for those determinations which present a factual issue, as determined by the commissioner, the residential health care facility may initiate a hearing to refute those items of the audit report adverse to the interests of the residential health care facility by serving on the commissioner by certified or registered mail a notice containing a statement of the legal

authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report together with copies of any documentation relied on by the residential health care facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the residential health care facility of the time and place of such hearing at least 15 days prior thereto.

The issues and documentation presented at such hearing shall be limited to the factual issues and documentation presented to the rate review panel.

(2) The final audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the residential health care facility to prove by substantial evidence that the items therein contained are incorrect.

(3) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and the State Administrative Procedure Act, which section 12-a reads as follows:

"§ 12-a. Formal hearings; notice and procedure

1. The commissioner, or any person designated by him for this purpose, may issue subpoenas and administer oaths in connection with any hearing or investigation under or pursuant to this chapter, and it shall be the duty of the commissioner and any persons designated by him for such purpose to issue subpoenas at the request of and upon behalf of the respondent.

2. The commissioner and those designated by him shall not be bound by the laws of evidence in the conduct of hearing proceedings, but the determination shall be founded upon sufficient legal evidence to sustain it.

3. Notice of hearing shall be served at least fifteen days prior to the date of the hearing, provided that, whenever because of danger to the public health it appears prejudicial to the interests of the people of the state to delay action for fifteen days, the commissioner may serve the respondent with an order requiring certain action or the cessation of certain activities immediately or within a specified period of less than fifteen days and the commissioner shall provide an opportunity to be heard within fifteen days after the date the order is served.

4. Service of notice of hearing or order shall be made by personal service or by registered or certified mail. Where service, whether by personal service or by registered or certified mail, is made upon an infant, incompetent, partnership, corporation, governmental subdivision, board or commission, it shall be made upon the person or persons designated to receive personal service by article three of the civil practice law and rules.[1]

5. The attorney-general may prefer charges, attend hearings, present the facts, and take any and all proceedings in connection therewith.

6. At a hearing, the respondent may appear personally, shall have the right of counsel, and may cross-examine witnesses against him and produce evidence and witnesses in his behalf.

7. Following a hearing, the commissioner may make appropriate determinations and issue an order in accordance therewith.

8. The commissioner may adopt, amend and repeal administrative rules and regulations govern-

ing the procedures to be followed with respect to hearings, such rules to be consistent with the policy and purpose of this chapter and the effective and fair enforcement of its provisions.

9. The provisions of this section shall be applicable to all hearings held pursuant to this chapter, except where other provisions of this chapter applicable thereto are inconsistent therewith, in which event such other provisions shall apply."

(h) Rate revisions resulting from the procedure set forth in this section may be made retroactive to the period or periods during which the rates based on the periods audited were established.

(i) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF ALBANY

Index No. 2801/76

In the Matter of the Application of

WHITE PLAINS NURSING HOME,

Petitioner,

against

ROBERT P. WHALEN, Commissioner of the Department of Health of the State of New York, and WILLIAM F. MCCANN, Assistant Commissioner Division of Health Economics, Department of Health of the State of New York,

Respondents.

MEMORANDUM DECISION

Supreme Court, Albany County Special Term, Part I, March 11, 1976

Justice William R. Murray, Presiding

(Calendar #48)

APPEARANCES:

For the Motion: Gasperini and Savage, Esqs.
Attorneys for Petitioner.

In Opposition: Hon. Louis J. Lefkowitz
Attorney General, State of New York
Attorney for Respondents.

MURRAY, J.:

Petitioner, by Order to Show Cause, moves for an Order pursuant to CPLR Article 78, anulling the determination of respondents wherein and whereby the payment of "imputed rental" was eliminated, pursuant to regulations

of the Commissioner as amended and set forth in 10 NYCRR 86.01 et seq., effective January 12, 1976; an order permanently enjoining respondents from eliminating reimbursement for rental costs; directing that all reimbursement withheld be reinstated and tendered to petitioner and declaring invalid the regulation promulgated by the Department of Health, 10 NYCRR 86.30, on the ground the regulation is in violation of Sections 2800, 2803 (2) and 2807 (3) of the Public Health Law and in violation of the Medicaid Provider Agreement between Petitioner and the State of New York.

Heretofore, and prior to February 1, 1975, petitioner had received rental reimbursement for actual rent paid to Cambridge Care Center Corporation, landlord, in accordance with its arm's-length lease, as alleged. Upon a determination by respondents that the lease was not an arm's-length transaction, petitioner received a reduced or "imputed rent". That decision was vacated by Special Term (Albany County, July 11, 1975) and the original arm's-length rate reinstated. Appeal by respondents has stayed execution of the judgment entered on Special Term's decision.

In early 1975, amendments to the regulations of the Department of Health were promulgated, providing for elimination of "imputed rental" and substituted approved property costs for consideration in the calculations of the medicaid rate. Such became effective June 1, 1975. Petitioner alleges that it has not been able to obtain any confirmation from its landlord, Cambridge, relating to "approved property costs" for submission to respondent, and that there is no apparent legal process whereby the Department of Health can compel disclosure of such costs.

As in the previous Article 78 proceeding (Special Term, July 11, 1975, #60) the determination herein was made without a hearing, and is found to be violative of the rights of the petitioner, and the rationale of that decision is

adopted herein. Pending a determination of the appeal to the Appellate Division the "imputed rent" will be reinstated, effective as of January 12, 1976.

It is found that the Commissioner's regulation (10 NYCRR 86.30) is a reasonable exercise of his authority to oversee and determine that rates are just, equitable and in the public interest, and is a lawful implementation of Section 2807 (3) of the Public Health Law.

Other issues raised and requests for relief thereon have been considered and are denied. Petitioner to submit Order in accordance with above.

Dated: May 11, 1976 at
Troy, New York.

WILLIAM R. MURRAY
Justice of the Supreme Court

SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF BRONX

Index No. 8222/77

WASHINGTON FEDERAL SAVINGS AND LOAN ASSOCIATION,
Plaintiff,

against

CAMBRIDGE CARE CENTERS CORPORATION, WHITE PLAINS NURSING HOME, THE PEOPLE OF THE STATE OF NEW YORK, AND THE CITY OF NEW YORK,
Defendants.

VERIFIED COMPLAINT

Plaintiff, by its attorneys, Demov, Morris, Levin & Shein, complaining of the defendants, alleges:

1. Plaintiff, Washington Federal Savings and Loan Association, formerly known as Washington Heights Federal Savings and Loan Association ("Washington Federal"), is and at all times hereinafter mentioned was a banking corporation organized and existing under the laws of the United States of America and is the lawful holder of the mortgage being foreclosed herein.

2. Upon information and belief, defendant Cambridge Care Centers Corporation ("Cambridge") is a corporation organized and existing under the laws of the State of New York with offices for the conduct of business at 250 West 57th Street, New York, New York and is the mortgagor of the mortgage being foreclosed herein.

3. Upon information and belief, defendant White Plains Nursing Home is the operating leasee of the premises being foreclosed herein.

4. The People of the State of New York is a party defendant in this action by reason of possible unpaid franchise taxes due and owing to it by defendant Cambridge.

5. The City of New York is a party defendant in this action by reason of possible unpaid general corporation taxes due and owing to it by defendant Cambridge.

6. On or about October 1, 1969, for value received, Cambridge executed and delivered its mortgage note (the "Mortgage Note") to Washington Federal promising to pay Washington Federal the sum of $1,725,000, or as much as was advanced, with interest, in accordance with the provisions of the Mortgage Note.

7. As collateral security for the payment of the Mortgage Note, Cambridge executed and delivered to Washington Federal a mortgage dated October 19, 1969 (the "Mortgage") whereby it mortgaged to Washington Federal the premises known as and by the street address of 3845 Carpenter Avenue, Bronx, New York (the "Mortgaged Premises"). The Mortgage was recorded in the Office of the City Register, Bronx County, on October 2, 1969 in Reel 117, Page 1329, and the mortgage tax imposed by law was paid. Annexed hereto as Exhibit A is a description of the Mortgaged Premises.

8. The terms of the Mortgage were modified in certain respects by written agreement between Cambridge and Washington Federal dated July 25, 1972.

9. The Mortgage, as so modified, provides, in part, as follows:

(a) Cambridge shall make principal payments, as well as tax and assessment escrow payments, on the first day of each month and every month;

(b) Cambridge shall be responsible for the payment of all real estate taxes, assessments, and water rates chargeable against the Mortgaged Premises; and upon default, Washington Federal may pay them;

(c) Upon Cambridge defaulting in the payment of any installment of interest or any tax, water rate or assessment for a period of thirty (30) days, the whole of the principal sum and interest due under the Mortgage shall become immediately due at the option of Washington Federal:

(d) In an action to foreclose the Mortgaged Premises, Washington Federal shall have the right to have a receiver appointed without notice and regardless of the adequacy of the security;

(e) In the event of a foreclosure sale, the Mortgaged Premises may be sold as a single parcel;

(f) In the event of default, Washington Federal shall be entitled to enter and take possession of the Mortgaged Premises;

(g) In the event of default in any payments due under the Mortgage for a period in excess of fifteen (15) days, a late charge of six ($.06) cents per dollar may be charged at the option of Washington Federal; and

(h) During the period of any default interest may be charged at the rate of eight (8%) percent per annum.

10. Cambridge has failed and refused to comply with the terms and conditions of the Mortgage by failing and refusing to pay installments of principal, interest and tax escrow due pursuant to the Mortgage Note from November 1, 1976 to the present, resulting in an indebtedness of $142,064.63 which debt is increasing each month.

11. Cambridge has further failed and refused to comply with the terms and conditions of the Mortgage by failing and refusing to pay real estate taxes and water and sewer

rent due on the Mortgaged Premises for a period in excess of thirty (30) days since payment of said taxes were due; consequently, the principal amount of said arrears now total $74,500.29.

12. Washington Federal is the lawful owner and holder of the Mortgage Note and Mortgage and has exercised its option to declare the entire principal sum of the Mortgage that has been advanced, in the present sum of $1,616,390.74, immediately due and payable.

13. By reason of the foregoing, there is now due and owing to Washington Federal from Cambridge under the aforesaid Mortgage Note and Mortgage the sum of $1,832,955.66, plus interest.

14. In order to protect its security, Washington Federal may be compelled, during the pendency of this action, to pay taxes, assessments, water or sewer rates, water meter charges, insurance premiums and other charges affecting the Mortgaged Premises, including amounts which may be due for labor and materials furnished thereto, and Washington Federal requests that any sums so paid by them shall be added to the sum otherwise due and be deemed secured by the Mortgage and adjudged a valid lien on the Mortgaged Premises.

15. No other action or proceeding has been brought for the relief sought herein.

16. Upon information and belief, all defendants herein have or claim to have some interest in or lien upon the Mortgaged Premises which interest or lien, if any, is subsequent and subordinate to the lien of Washington Federal.

17. Upon information and belief, no persons other than the parties herein have or claim to have a lien upon the Mortgaged Premises.

WHEREFORE, Washington Federal demands judgment:

1. That defendants, and all persons claiming under them, or any of them, subsequent to the filing of the notice of pendency in this action in the Office of the County Clerk, Bronx County, be forever barred and foreclosed of all right, title, claim, lien and equity of redemption in the Mortgaged Premises;

2. That the Mortgaged Premises be sold as a single parcel according the law and that the monies arising from the sale thereof be brought into Court, and that there be paid therefrom, insofar as the monies properly applicable thereto will pay the same, the expenses of the sale, the balance of the indebtedness on the aforesaid Mortgage Note and Mortgage, including attorney's fees, with interest and the costs and disbursements of this action, and any sum or sums which have been paid or which may hereafter be paid by Washington Federal for insurance premiums, taxes, water rates, sewer rents, or charges or assessments on the Mortgaged Premises, together with any expenses attending the same, with interest thereon to the date of payment;

3. Appointing during the pendency of this action a receiver of the Mortgaged Premises and of the earnings, revenues, rents, issues, profits and income therefrom with the usual powers and duties; and

4. Awarding Washington Federal such other and further relief as to the Court shall seem just and equitable, including the costs and disbursements of this action.

DEMOV, MORRIS, LEVIN & SHEIN
Attorneys for Washington Federal
40 West 57th Street
New York, New York 10019
(212) 757-5050

SCHEDULE A

Title No. 77-W-06851

DESCRIPTION

ALL that certain lot, piece or parcel of land situate, lying and being in the City of Mount Vernon, County of Westchester and State of New York, known and designated as the Southerly 36.875 feet of Lot 853 on Map entitled, Map of Mount Vernon made by Andrew Fidlay, Surveyor, dated June 7, 1851 and filed in the Office of the County Clerk, Division of Land Records, formerly Register's Office of Westchester County, on December 22, 1851 as Map No. 144, which portion of said lot is bounded and described as follows:

BEGINNING at a point on the westerly side of South 10th Avenue distant 501.00 feet southerly from the corner formed by the intersection of the Westerly side of South 10th Avenue with the southerly side of West 3rd Street and which point is also the northeast corner of Lot 852 on said map; running thence westerly along the boundary line between Lots 852 and 853 and at right angles to the westerly side of South 10th Avenue, 105.24 feet to Lot 1095 on said map; running thence northerly along said Lot 1095 and at right angles to the last described course, 36.875 feet to a point; running thence at right angles to said last mentioned line through said Lot 853, 105.24 feet to the westerly side of South 10th Avenue aforesaid; running thence southerly along said westerly side of South 10th Avenue 36.875 feet to the point or place of beginning.

VERIFICATION

State of New York
County of New York } ss.:

PETER MCKIBBIN, being duly sworn, deposes and says:

Deponent is Assistant Vice President of Washington Federal Savings and Loan Association, a federal banking corporation, plaintiff in the within action.

Deponent has read the foregoing complaint and knows the contents thereof; and the same is true to deponent's own knowledge, except as to the matters therein stated to be alleged upon information and belief, and as to those matters deponent believes it to be true.

This verification is made by deponent because Washington Federal Savings and Loan Association is a corporation, and deponent is an officer thereof. The grounds of deponent's belief as to all matters not stated upon deponent's knowledge are as follows: The books, records and files of said corporation and filed documents of public record.

PETER MCKIBBIN
Assistant Vice President

Sworn to before me this 28 day of April, 1977.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

Index No. 16216/77

WASHINGTON FEDERAL SAVINGS AND LOAN ASSOCIATION,
Plaintiff,

against

WHITE PLAINS NURSING HOME, a partnership,
Defendant.

COMPLAINT

Plaintiff, by its attorneys, Demov, Morris, Levin & Shein, complaining of the defendant, alleges:

1. Plaintiff, Washington Federal Savings and Loan Association, formerly known as Washington Heights Federal Savings and Loan Association ("Washington Federal"), is and at all times hereinafter mentioned was a banking corporation organized and existing under the laws of the United States of America.

2. Upon information and belief, defendant White Plains Nursing Home is a partnership organized and existing under the laws of the State of New York with offices for the conduct of business at 3845 Carpenter Avenue, Bronx, New York and is the operator of a proprietary nursing home at said location.

3. On or about October 1, 1969 Cambridge Care Center Corporation ("Cambridge") executed and delivered to Washington Federal a note and, as collateral security for

the indebtedness, a mortgage of even date whereby it mortgaged to Washington Federal the premises known as and by the street address of 3845 Carpenter Avenue, Bronx, New York (the "demised premises"). The terms of said mortgage were modified in certain respects by a written agreement between Cambridge and Washington Federal dated July 25, 1972.

4. That mortgage, as so modified, provided, in pertinent part, that the rents, issues, profits and all leases of the demised premises were collaterally assigned to Washington Federal as security for the payment of the indebtedness secured by the said note and mortgage, said assignment to be effective upon the default of Cambridge in complying with the terms, covenants, conditions, and agreements contained in the note and the mortgage.

5. Upon information and belief, by agreement of lease dated December 4, 1971 (the "lease") Cambridge leased the demised premises to defendant White Plains Nursing Home ("White Plains") for a term of ten (10) years at a minimum rent of $444,000 per year plus additional rent as provided for in the lease.

6. Cambridge has been continuously in default under the terms, conditions, covenants and agreement of the note and the mortgage since November 1, 1976.

7. On or about March 15, 1977, Washington Federal formally advised White Plains of the default under the mortgage and of White Plains' obligation to make all further payments of rent and additional rent due under the lease to Washington Federal until further notice.

8. Nevertheless, White Plains has failed and refused to pay all rents and other payments due under the terms of the lease to Washington Federal, resulting in an indebtedness to Washington Federal of $296,000 plus accrued and

unpaid real estate taxes, water frontage charges, sewer charges and other items of additional rent, with said sum increasing on a monthly basis.

WHEREFORE, Washington Federal demands judgment against White Plains in the sum of $296,000 plus accrued and unpaid real estate taxes, water frontage charges, sewer charges and other items of additional rent on the demised premises, as well as appropriate interest and the costs and disbursements of this action.

Yours, etc.

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And Loan Association
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